Home Health Certification and Plan of Care

Order ID: 1150/13630

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
18116567	10/14/2025	From: 10/14/2025 To: 12/11/2025	9393	217058

6. Patient's Name and Address

Darlene Wilson
1700 Edmondson Avenue . APT 111,
BALTIMORE, MD 21223-
443-438-5646

7. Provider's Name, Address and Telephone Number

HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 04/25/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	10/14/25

13. ICD	Other Pertinent Diagnoses	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	10/14/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	10/14/25
N18.6	End stage renal disease	10/14/25
J44.9	Chronic obstructive pulmonary disease unspecified	10/14/25
E78.5	Hyperlipidemia unspecified	10/14/25
E11.43	Type 2 diabetes w diabetic autonomic (poly)neuropathy	10/14/25
K31.84	Gastroparesis	10/14/25
E11.3592	Type 2 diab with prolif diab rtnop without mclr edema l eye	10/14/25
E11.3311	Type 2 diab with mod nonp rtnop with macular edema r eye	10/14/25
N25.81	Secondary hyperparathyroidism of renal origin	10/14/25
I70.0	Atherosclerosis of aorta	10/14/25
H40.9	Unspecified glaucoma	10/14/25
Z99.2	Dependence on renal dialysis	10/14/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	10/14/25

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Vitamin B - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Capsule by mouth once a day
Amlodipine - Amlodipine Besylate 10 Mg, 1 Tab by mouth once a day Blood pressure
Sevelamer Carbonate - Sevelamer Carbonate 800 Mg, Take 2 tablet by mouth twice a day Kidney dz
Atorvastatin Calcium - Atorvastatin Calcium 40 Mg, 1 Tab by mouth once a day Cholesterol
Metoprolol Tartrate - Metoprolol Tartrate 100 Mg, 1 Tab by mouth twice a day Blood pressure
Aspirin - Aspirin 81 Mg, 1 Tab by mouth once a day Blood thinner
Albuterol Sulfate - Albuterol Sulfate 90 Mcg, 1 Puff inhalant every 6 hours Asthma
Glipizide - Glipizide 5 Mg by mouth once a day DM
Cinacalcet Hydrochloride - Cinacalcet Hydrochloride 30 Mg, 1 Tab by mouth once a day CKD. Administered at HD
Cardura - Doxazosin Mesylate eq 1 mg base 1mg 2 tabs by mouth at bedtime HTN
Azelastine - Azelastine Hydrochloride 0.1% nasal twice a day allergies

14. DME and Supplies:

diabetic supplies, walker, bath bench, cane

15. Safety Measures:

diabetic precautions, walker precautions, supervision at all times, , bathroom safety, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

renal diet, diabetic, low sodium

17. Allergies:

penicillin amoxicillin atorvastatin lisinopril oxycodone spironolactone venlafaxin

18.A. Functional Limitations

Ambulation, Endurance,

18.B. Activities Permitted

Walker, Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 Diabetes Mellitus With Hypoglycemia Without Coma, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:

The patient is a 70-year-old female with a complex medical history including end-stage renal disease (ESRD) on hemodialysis (Monday, Wednesday, Friday), chronic kidney disease (CKD) stage 5, type 2 diabetes mellitus with episodes of hypoglycemia, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), atherosclerosis of the aorta, hyperparathyroidism, glaucoma, transient ischemic attack (TIA), and poor appetite. She was recently hospitalized for repair of a left arm arteriovenous (AV) fistula and evaluation of unintentional weight loss. The patient resides with her husband in an elevator-accessible apartment, and her daughter-who is also her power of attorney-serves as the primary caregiver, organizing medications into a pillbox for compliance, while the husband assists with daily administration and care. The patient is alert and oriented, presenting with generalized weakness, deconditioning, and ambulatory difficulties that increase her fall risk, necessitating the use of a rollator walker and close supervision for safety. She ambulates approximately 30 feet indoors with assistance and performs sit-to-stand and toilet transfers with contact guard assistance and verbal cueing for proper limb positioning. Bed mobility requires moderate assistance, and transfers from low surfaces such as a folding chair also require moderate assistance. Due to significant effort required to leave the home and her limited endurance, she is considered homebound, supported by a Tinetti balance and gait score of 7/28. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient denies pain and reports reduced urinary output, consistent with ESRD on dialysis. The right chest dialysis access site is intact without signs of infection or complications. Lung sounds are clear to auscultation bilaterally, and no abnormal bleeding or wounds are noted. The patient reports poor appetite and relies on nephron supplement drinks as meal replacements. She also reports intermittent difficulty swallowing medications and certain foods, requiring monitoring and dietary modification as needed. Medication reconciliation was completed and reviewed with both the patient and caregivers to ensure understanding of dosages, indications, and administration times. Education was provided regarding fluid restriction management, blood glucose monitoring, and the importance of maintaining activity throughout the day to prevent further deconditioning. The caregiver monitors the patient's glucose levels using both a continuous glucose monitor (CGM) and a glucometer, with recent readings of 72 mg/dL (CGM) and 127 mg/dL (glucometer). The patient was also instructed to avoid prolonged periods in bed during the day to promote mobility and improve sleep quality at night. The plan of care includes continued skilled nursing oversight for disease management, medication education, monitoring of nutritional intake and dialysis site integrity, and coordination with physical and occupational therapy to address strength deficits, balance, and safe mobility training to promote independence. Ongoing reinforcement of diabetic management, fall prevention strategies, and caregiver support will be maintained to optimize the patient's safety and overall well-being.
 Date of

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 10/14/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jerry Katz
5310 Old Court Rd
Randallstown, MD 21133
PHONE: FAX: NPI: 1790761625

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

F2F date : 10/09/2025

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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Order 10/14/2025 Orders Physician Face-to-Face Date: 10/09/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Type 2 Diabetes Mellitus With Hypoglycemia Without Coma Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Katz, Jerry

SN Careplans

SN WK1: 1 (10/14/25-10/18/25) ,WK2: 1 (10/19/25-10/25/25) ,WK3: 1 (10/26/25-11/01/25) ,WK4: 1 (11/02/25-11/08/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, abn cholesterol > 200 mg/dL, abnormal blood pressure, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, abnormal BS < 70/140 > mg/dL, poor muscle tone, muscle weakness, limited endurance, limited strength, daytime fatigue, balance deficit, B1000 - Vision Deficit, loss of appetite

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * low cholesterol dietary guidelines, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: to increase strength and mobility

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/14/2025

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* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (10/14/25-10/18/25) ,WK2: 2 (10/19/25-10/25/25) ,WK3: 2 (10/26/25-11/01/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, Bed mobility training , cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To be able to move around the house by myself

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (10/19/25-10/25/25) ,WK3: 1 (10/26/25-11/01/25) ,WK4: 1 (11/02/25-11/08/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: ADLs , Patient/caregiver recalls related purpose and schedule of medications: Medication review , cough/deep breathing exercises, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
10/14/2025